Accordingly, one must consider other approaches of potential value in reducing mortality from sudden cardiovascular collapse in addition to implementation of effective mobile intensive care units. Possibilities include:

- Identification of populations at high risk suitable for prophylactic anti-arrhythmia drug administration.
- Precoronary care in special facilities available for self-referring patients attuned to the significance of prodromata.
- Utilization of electronic devices such as automatic self-contained catheter-defibrillation systems in selected patients at high risk.
- Aggressive surgical therapy designed to correct ischemia in selected patients before the onset of lethal dysrhythmia.
- Prevention of coronary artery disease with diet and other metabolic and pharmacologic interventions.

Many of these approaches depend on identification of criteria to define discrete, manageable populations of patients at particularly high risk. Since ventricular fibrillation appears to be responsible for most sudden death, premorbid electrocardiographic criteria have been sought. The instance of sudden death is 3 to 10-fold increased in patients with frequent ventricular premature beats, as was shown by Hinkle and coworkers[7] and in the Tecumseh study. Certain types of ventricular premature beats, such as those increased by exercise, those originating from the left ventricle, those falling during the vulnerable period, and those occurring in salvos appear particularly likely to precipitate sudden death. Unfortunately, however, precise selection of a population at high risk on the basis of ventricular premature beats is difficult because the phenomenon is so common, especially in older age groups. Perhaps, assessment of ventricular fibrillation thresholds in selected subjects will ultimately prove useful in this regard.

Risk factors such as hypertension, hyperlipidemia, diabetes mellitus, or previous overt coronary artery disease are present in most victims of sudden death. Unfortunately, populations at risk defined by such criteria are huge.

Most patients with acute myocardial infarction exhibit prodromata — usually chest pain — in the weeks preceding the acute episode. Even assuming that such prodromata generally precede sudden death as well, and that vigorous educational efforts succeed in encouraging patients to seek medical attention promptly, the difficulties of defining a manageable high risk population are formidable, if only because the symptoms are so common.

Thus, despite considerable progress, until more precise definition of risk is possible, widespread application of potentially hazardous prophylactic approaches to sudden death is not warranted. What has become clear is that a significant inroad on the overall mortality from sudden cardiovascular collapse and death will be possible only with a well integrated, multi-faceted program developed in part on the basis of ongoing research concerning risk factors; data processing and data reduction; instrumentation; patient and physician education; pharmacologic, metabolic, and surgical prophylaxis; as well as performance of paramedical personnel in mobile intensive care facilities.

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It Could Be an Historic Action

EARLIER THIS YEAR the American Medical Association and the American Nurses' Association created The National Joint Practice Commission (NJPC). This was done in response to a recommendation of the National Commission for the Study of Nursing and Nursing Education which strongly urged the establishment of joint practice commissions between medicine and nursing

which would examine changing health care needs and functions and thus recommend improved practice roles for *both* medicine and nursing. The NJPC is now in the organizational phase at the national level and is actively encouraging the formation of state joint practice committees. One of them has been created in California.

One senses this action may well turn out to be of considerable historic significance, although it remains to be seen how much of a precedent has been set. However, two things appear to have been accomplished. The health team concept took a significant step forward when medicine and nursing agreed to establish a joint practice commission, and at the same time the nursing profession became recognized as a considerably more equal partner with the medical profession in patient care. Historic acts only become fully recognized in retrospect but they are apt to have historic consequences long before this recognition occurs. The historic consequences if any, of this joint action of the AMA and the ANA can at best be only dimly perceived at present.

But a look at the professed objectives and priorities of the NJPC may give some clue. These are understood to include (1) examination of roles and functions in medical and nursing practice with definition of new and altered patterns; (2) definition, identification and examination of health care needs; (3) improve communication between medicine and nursing to enhance joint planning and action; (4) propose changes in educational patterns and relationships that would enhance the new role functioning of nurses and physicians; (5) address the traditional problems which affect nurse-physician relationships in order to establish enhanced role functioning; (6) encourage and assist in the development of state counterpart joint practice committees; and (7) identify and address the ensuing problems related to the basic role reorganization.

There appears to be little that suggests preservation of the status quo in these announced objectives and priorities of the NJPC, and it seems quite likely that a new and no doubt powerful force has appeared upon the professional health care scene, one which quite clearly expects to bring about substantive rearrangements in the professional power structure at all levels of health care. Paradoxical as it may seem, this new alignment of medicine and nursing seems likely to presage both more coordination of patient care, which is desirable, and at the same time more fractionation among the health professions, which may or may not be so desirable. In any case a precedent seems to have been established, and the way therefore opened for other professionals on the health care team to become increasingly recognized as actively participating partners in decision-making for medical and health care.

The primary concern of all should of course be the welfare of the patient, and it remains to be seen whether or to what extent the patient will benefit. It would seem likely that to the degree better coordination of patient care is achieved, the patient will indeed benefit, and to the degree that fractionation and divisions among a gaggle of health professions dominate the scene, the patient will inevitably suffer. We hope that the forces for cohesion will outweigh the forces for division, but suspect that to bring this off will take a bit of doing, particularly by physicians, who must clarify the role of the medical profession as new arrangements with other professions in patient care inevitably evolve.

—MSMW